

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:
03-009

2. STATE
Wisconsin

FOR: HEALTH CARE FINANCING ADMINISTRATION

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE
SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
07/01/03

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.250

7. FEDERAL BUDGET IMPACT:
a. FFY 2003 (\$3,800K)
b. FFY 2004 (\$16,000K)

8. CURRENT PAGES:
i, ii, iii, iv, 1, 3, 5, 6, 6.1 to 6.2, 7, 8, 11, 15, 20, 33.2, 33.3,
33.4, 34, 36, 43, 43.3, 43.4, 43.5, 46, 48, 50, 51, 52
6.3 to 6.5, 7.2, 7.4, 7.5, 10.1, 14.1, 26.1.a., 26.1.b., 26.1.c.,
43.1.b, 43.2.b, 62, 63, 64
7.3
43.1.a
43.2.a

9. NEW PAGES:

Same

None

7.1

43.1

43.2

10. SUBJECT OF AMENDMENT:
Inpatient Hospital Rates

11. GOVERNOR'S REVIEW (Check One):

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☐ OTHER, AS SPECIFIED:

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FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

SEP 29 2003

18. DATE APPROVED:

APR 29 2004

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

JUL - 1 2003

20. SIGNATURE OF REGIONAL OFFICIAL:

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RECEIVED

SEP 29 2003

DMCH - MI/MN/WI

**Wisconsin Medicaid Program
Inpatient Hospital State Plan
Method and Standards For Determining Payment Rates
With Amendments Effective July 1, 2003**

******* TABLE OF CONTENTS *******

Page

1000 OVERVIEW OF INPATIENT HOSPITAL REIMBURSEMENT.....	1
2000 STATUTORY BASIS	2
3000 DEFINITIONS	2
3500 DIFFERENCES IN RATE SETTING BETWEEN IN-STATE AND OUT-OF-STATE HOSPITALS	3
Hospitals Located in Wisconsin	
Hospitals Not Located In Wisconsin and Border Status Hospitals	
4000 COST REPORTING	4
General	
Cost Report Due Date -- In-State Hospitals	
-- Major Border-Status Hospitals	
Gains and Losses of Depreciable Assets	
Allowed Capital Cost Upon Change of Ownership	
5000 DRG BASED PAYMENT SYSTEM for In-state Hospitals and Major Border Status Hospitals	5
5020 HOSPITALS COVERED BY DRG SYSTEM	5
5030 SERVICES COVERED BY DRG PAYMENTS	5
5040 PROFESSIONAL SERVICES EXCLUDED FROM DRG PAYMENTS	5
5100 STANDARDIZED DRG PAYMENT FACTORS	6
DRG Groupers	
DRG Weights	
DRG Weights for MDC 15, Mental Diseases and Disorders	
Standard DRG Group Rates	
5200 HOSPITAL-SPECIFIC DRG BASE RATE	8
Calculation Of Hospital-Specific DRG Base Rate, General	8
Wage Area Adjustment Index	8
Disproportionate Share Adjustment Percentage	11
Rural Hospital Adjustment Percentage	14
5300 OUTLIER PAYMENTS UNDER DRG PAYMENT SYSTEM	15
Cost Outliers.....	15
Length of Stay Outliers.....	17

Page i

APR 29 2004

Approval Date _____

Effective Date 07/01/03

	<u>Page</u>
5400 CAPITAL COSTS PAYMENT UNDER DRG PAYMENT SYSTEM	18
Calculation for Hospitals Located In Wisconsin	
Calculation for Major Border Status Hospital	
Exemption From Capital Reduction	
5500 DIRECT MEDICAL EDUCATION PAYMENT UNDER DRG PAYMENT SYSTEM.....	20
Calculation for Hospitals Located In Wisconsin	
5800 OTHER PROVISIONS RELATING TO DRG PAYMENTS	23
Medically unnecessary stays	Authority for recovery
WIPRO Review	WIPRO control numbers
Inappropriate inpatient admission	Transfers
Inappropriate discharge/readmission	Days awaiting placement
DRG validation review	IMD hospital transfers
Changes of ownership	HMO/PEI alternative payment
Outpatient services related to inpatient stay	
Obstetrical and newborn same day admission/discharge	
Cost report used for establishing rates for hospitals combining operations	
Provisions relating to organ transplants	
5900 REIMBURSEMENT FOR CRITICAL ACCESS HOSPITALS	25.1
6000 HOSPITALS PAID UNDER PER DIEM RATE.....	26
6200 PAYMENT RATES FOR STATE MENTAL HEALTH INSTITUTES.....	26
6300 CALCULATION METHODOLOGY FOR REHABILITATION HOSPITALS	26.2
6400 OTHER PROVISIONS RELATING TO PER DIEM RATE SYSTEM	28
Medically unnecessary days, defined	Authority for recovery
Calculation of recoupment	WIPRO review
WIPRO control numbers	Inappropriate inpatient admission
Days awaiting placement	Temporary hospital transfers
Outpatient services related to inpatient stay	Changes of ownership
HMO/PEI alternative payment	
Cost report used for establishing rates for hospitals combining operations	
7000 SERVICES EXEMPTED FROM THE DRG PAYMENT	29
7100 PAYMENT FOR ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS).....	29
7200 PAYMENT FOR VENTILATOR-ASSISTED PATIENTS	30
7400 NEGOTIATED PAYMENTS FOR UNUSUAL CASES	31
7500 BRAIN INJURY CARE.....	31
7900 PAYMENT RATES FOR SERVICES EXEMPTED FROM DRG PAYMENT SYSTEM.....	32
8000 FUNDING OF MEDICAID DEFICIT IN GOVERNMENTAL HOSPITALS	33
8100 SUPPLEMENTAL PAYMENTS FOR ESSENTIAL ACCESS CITY HOSPITALS (EACH).....	33.1
8200 GENERAL ASSISTANCE DISPROPORTIONATE SHARE HOSPITAL ALLOWANCE	33.2
8400 SUPPLEMENTAL PAYMENT FOR MAJOR MANAGED CARE HOSPITAL PROVIDERS (Not in Milwaukee County)	33.6.b
8500 PEDIATRIC INPATIENT SUPPLEMENT.....	33.6.c
9000 PAYMENT NOT TO EXCEED CHARGES.....	33.6.c
9100 LIMIT ON AMOUNT OF DISPROPORTIONATE SHARE PAYMENT TO A HOSPITAL	33.7

	<u>Page</u>
10000 PAYMENT OF OUT-OF-STATE MINOR BORDER STATUS & NON-BORDER STATUS HOSPITALS	34
10200 DRG BASED PAYMENT SYSTEM	34
Base DRG Rate	
Wage Area Adjustment Index	
Capital Cost Payment	
Payment for Psychiatric Stays	
Cost Outliers	
10300 PAYMENT NOT TO EXCEED CHARGES	35
10400 ADMINISTRATIVE ADJUSTMENT ACTIONS	35
Reduced Payment Possible	
Request Due Date and Adjustment Effective Date	
Effective Period	
10460 CRITERIA FOR ADMINISTRATIVE ADJUSTMENTS	36
For Minor Border Status and Non-border Status Hospitals	
Adjustment for being a hospital institution for mental disease (IMD)	
Adjustment of capital cost payment	
Disproportionate share adjustment applied to payments	
Adjustment of cost outlier tripoint for hospitals under 100 beds	
Facility-specific cost-to-charge ratio for use in outlier payment calculation	
Correcting adjustment due to inappropriate calculation of adjustments	
Per Diem Rate for Out-of-State Rehabilitation Hospitals	
10600 OUT-OF-STATE HOSPITAL RATES, STANDARDIZED AMOUNTS	38
11000 ADMINISTRATIVE ADJUSTMENT ACTIONS For In-State and Major Border Status Hospitals	39
Hospital's Submission of Request for Adjustment	39
Due Date of Request and Effective Date of Adjustment	40
Initiation of Adjustment by Department	40
Reduced Payment Possible	40
Withdrawal	40
Effective Period of an Administrative Adjustment	40
The 60 Day Rule	40
Definition, "Delivery date"	
Definition, "Final rate notification"	
Requested by Hospital Within 60 Days After Rate Notification	
Requested by Hospital After 60 Days From Rate Notification	
Requested by Hospital Before New Rate Year Begins	
.... Administrative Adjustments Initiated by the Department	
Correction of Inappropriate Calculations	

	<u>Page</u>
11900 CRITERIA FOR ADMINISTRATIVE ADJUSTMENT ACTIONS	42
For in-state and major border-status hospitals	
A. Correction of Inappropriate Calculation of Rates	42
B. Use More Current Cost Report If Available Cost Report Is More Than 3 Years Old	43
C Capital Payment Adjustment for Major Capitalized Expenditures, Eff January 1, 1996	43.1a
 D Adjustment for Changes in Medical Education, Effective July 1, 2003	 43.2.a
 F. Reclassification of Hospital to Different Wage Area	 43.3
 I. Adjustment for PEI Ceasing to be Mandatory	 43.5
K. Eligibility for Rural Adjustment Considering Days Provided Under Out-of-State Medicaid Programs and/or Other Governmental Programs	 43.5
L. Adjustment to Rural Adjust Percent for Substantial Increase in Medicaid Utilization	43.6
M. Adjustment to Rural Adjust Percent for Recognition of Out-of-State Medicaid Days	43.6
N. Recalculation of DSH Cost Limitation of '9100 With Additional Information	43.7
O. Recalc of DSH Cost Limit of '9100 Upon Settlement of Outpatient Reimbursement	43.7
P. Claim Adjustment For Length Of Stay Outlier	43.7
Q. Adjustment For Hospital Expecting Payment To Exceed Charges	43.7
R. Disproportionate Share Adjustment for New Hospital	43.8
S. Adjustment for Combining Hospitals	43.8
 APPENDICES	
21000 Listing Of Hospitals Exempt From Capital Reduction	45
22000 Example Calculation - Hospital Specific DRG Base Rate	46
23000 Example Calculation - Hospital Specific Base Capital Payment	47
24000 Example Calculation - Hospital Specific Base Direct Medical Education Payment	48
24500 Example Calculation - Cost Outlier Payment	49
27000 Area Wage Indices	50
27100 Disproportionate Share Adjustment Amounts	51
27200 Inflation Rate Multipliers for Administrative Adjustments	52
28000 Policies and Procedures for Administrative Adjustment	55
 End of Hospital Inpatient State Plan	 64

**Wisconsin Medicaid Program
Inpatient Hospital State Plan
Method and Standards For Determining Payment Rates**

**SECTION 1000
OVERVIEW OF INPATIENT HOSPITAL REIMBURSEMENT**

This section is a brief overview of how reimbursement to hospitals is determined for inpatient services that are provided by hospitals to eligible recipients of the Wisconsin Medicaid Program (WMP). The WMP uses a reimbursement system which is based on Diagnosis Related Groupings (DRGs). The DRG system covers acute care hospitals and hospital institutions for mental disease (IMDs). Excluded from the DRG system are rehabilitation hospitals, State IMDs and State veterans hospitals which are reimbursed at rates per diem. Also, reimbursement for certain specialized services are exempted from the DRG system. These include acquired immunodeficiency syndrome (AIDS), ventilator-assisted patients, unusual cases and brain injury cases. Special provisions for payment of each of these DRG exempted services are included in the plan. As of July 1, 1995, organ transplants are covered by the DRG system.

The WMP DRG reimbursement system uses the grouper that has been developed for and used by Medicare, with enhancements for certain perinatal, newborn and psychiatric cases. The grouper is a computer software system that classifies a patient's hospital stay into an established diagnosis related group (DRG) based on the diagnosis of and procedures provided the patient. The WMP applies the Medicare grouper and its enhancements to Wisconsin-specific claims data to establish a relative weight for each of over 550 DRGs based on statewide average hospital costs. These weights are intended to reflect the relative resource consumption of each inpatient stay. For example, the average hospitalization with a DRG weight of 1.5 would consume 50 percent more resources than the average hospitalization with a weight of 1.0, while a hospital stay assigned a DRG with a weight of .5 would require half the resources.

Each hospital is assigned a unique "hospital-specific DRG base rate". This hospital-specific DRG base rate includes an adjustment for differences in wage levels between rural and metropolitan areas throughout the state. This rate also includes an amount, based on the hospital's historical costs, for capital cost and for direct costs of medical education programs. For some hospitals, the rate also includes additional amounts for a serving a disproportionate share of low-income persons or for the hospital being located in a rural area.

Given a hospital's specific DRG rate and the weight for the DRG into which a stay is classified by the grouper, payment to the hospital for the stay is determined in multiplying the hospital's rate by the DRG weight.

A "cost outlier" payment is made when the cost of providing a service exceeds a pre-determined "trimpoint". Each inpatient hospital claim is tested to determine whether the claim qualifies for a cost outlier payment. A length-of-stay outlier payment is available upon a hospital's request for children under six years of age in disproportionate share hospitals and for children under age one in all hospitals.

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DRG. DRG means Diagnosis Related Groups which is a patient classification system that reflects clinically similar groupings of services that can be expected to consume similar amounts of hospital resources.

Hospital-Specific DRG Base Rate. The payment rate per discharge which will be calculated for and assigned to each hospital by the Department for the rate year. This is the rate by which a DRG weight is multiplied to establish the amount of payment for an individual inpatient stay. Some provisions may allow this rate to change during the rate year.

IMD. Institution for Mental Disease, as defined in 42 CFR 435.1009. When used in this Plan, IMD means "hospital IMD".

Long Term Care Hospital. An acute care hospital reimbursed by Medicare under the Medicare prospective payment system for long-term care hospitals (LTCH).

Non-Border Status Hospital. A hospital not located in Wisconsin and which has not been certified by the WMAP as a border status hospital.

Prospective Rate per Diem. The hospital-specific rate for each day of service.

Rate Year. The twelve month period from July 1 through June 30 during which rates established under the annual rate update are to be effective for most, if not all, hospitals.

Rehabilitation Hospital. A hospital that provides intensive rehabilitative services for conditions such as stroke, brain injury, spinal cord injury, amputation, hip fractures, and multiple trauma to at least 75% of its patient population. IMD hospitals cannot be considered rehabilitation hospitals under the provisions of this plan.

WMAP. Wisconsin Medical Assistance Program, also referred to as Medicaid, Medical Assistance (MA) or Title XIX.

SECTION 3500 DIFFERENCES IN RATE SETTING BETWEEN IN-STATE HOSPITALS AND OUT-OF-STATE HOSPITALS

3510 Hospitals Located in Wisconsin

General hospitals and most specialty hospitals located in Wisconsin (in-state hospitals) are reimbursed according to the DRG based payment method described in section 5000 herein. All inpatient stays are reimbursed under the DRG based payment method except AIDS patient care, ventilator patient care, unusual cases and brain injury care will be reimbursed under the alternative payment methods described in section 7000 if the hospital requests and qualifies for the alternative reimbursement according to section 7000. As of July 1, 1995, organ transplants are paid under the DRG based payment method.

Certain specialty hospitals are reimbursed under a rate per diem methodology, not the DRG based payment system. Rehabilitation hospitals as defined in section 3000 are paid a per diem rate according to section 6300. The State's mental health institutes are paid under the payment rates described in section 6200. State operated hospitals which primarily service military veterans are paid under the payment rates described in section 6250.

Administrative Adjustment of Rates. In-state hospitals may request an administrative adjustment to their payment rates under the criteria described in section 11000. The due dates for requesting adjustments are described in that section.

Use of Cost Report In Rate Setting. An in-state hospital's audited cost report is required for establishing certain components of the hospital's specific payment. The specific components include the disproportionate share adjustment (§5240), the rural hospital adjustment (§5260), outlier payments (§4322), capital cost payments (§5420) and the direct medical education payments (§5520).

SECTION 5000
DRG BASED PAYMENT SYSTEM
FOR IN-STATE HOSPITALS AND MAJOR BORDER STATUS HOSPITALS

5010 INTRODUCTION

A hospital is paid a prospectively established amount for each discharge under the DRG based payment system. In the Department's annual rate update, a "hospital-specific DRG base rate" is calculated for each hospital. This rate is the result of adjusting a "standard DRG group rate" for the wage area of each hospital. In addition, if the hospital qualifies, the rate includes disproportionate share (§5240) or rural hospital adjustments (§5260). As of July 1, 1997, the hospital-specific DRG base rate includes payment for capital costs (§5400) and direct medical education costs (§5500). As of July 1, 1999, the indirect and direct medical education costs are not included in out-of-state hospital-specific DRG base rates. As of July 1, 2003, an indirect medical education cost adjustment is not included in any hospital-specific DRG base rate.

For each Medicaid recipient's stay, a hospital's specific DRG base rate is multiplied by the relative weighting factor for the diagnosis related group (DRG) which applies to the hospital stay. The result is the DRG payment to the hospital for the specific stay. In addition to the DRG payment, an "outlier" payment may be made to the hospital for very high cost cases which are described in sections 5321 through 5324 or for certain very long lengths of stay which are described in sections 5331 through 5334.

5020 HOSPITALS COVERED BY DRG SYSTEM

Most general, specialty and IMD hospital providers in Wisconsin and most major border status hospitals will be paid according to the DRG based payment system described in this section 5000. Minor border status hospitals, out-of-state non-border status hospitals, rehabilitation hospitals, and State operated IMD hospitals and veteran hospitals are not covered by this section 5000.

5030 SERVICES COVERED BY DRG PAYMENTS

All covered services provided during an inpatient stay, except professional services described in §5040, shall be considered hospital inpatient services for which payment is provided under this DRG based payment system. (Reference: Wis. Admin. Code, HSS 107.08(3) and (4))

All inpatient stays are reimbursed under the DRG based payment method except AIDS patient care, ventilator patient care, unusual cases and brain injury care will be reimbursed under the alternative payment methods described in section 7000 if the hospital requests and qualifies for the alternative reimbursement according to section 7000.

As of July 1, 1995, organ transplants are covered by the DRG based payment method.

5040 PROFESSIONAL SERVICES EXCLUDED FROM DRG PAYMENTS

Certain professional and other services are excluded from the DRG payment system. Professional services must be billed by a separately certified provider and billed on a claim form other than the UB-92 hospital claim form. The following services are excluded, when the professionals are functioning in the capacity of:

Physicians	Optometrists	Pharmacy, for take home drugs on the date of discharge
Psychiatrists	Hearing aid dealers	
Psychologists	Audiologists	Durable medical equipment and supplies for non-hospital use
Physician assistants	Podiatrists	
Nurse midwives	Independent nurse practitioners	Specialized medical vehicle transportation
Chiropractors	Anesthesia assistants	
Dentists	Certified registered nurse anesthetists	Air, water and land ambulance

5100 STANDARDIZED DRG PAYMENT FACTORS

Certain standard factors are used in the determining the amount of payment hospitals receive for services covered by the DRG based payment method. The Department adjusts these standard factors for each rate year, July 1 through June 30. They include the DRG grouper, the DRG weights and the standard DRG group rates.

5130 DRG Grouper

The DRG grouper is a patient classification software system which results in a patient stay being classified into one "diagnosis related group" (DRG). The WMP DRG reimbursement system uses the grouper developed for Medicare based on "major diagnostic categories" (MDCs). For newborns, WMP has enhanced the grouper's MDC 15, Newborns and Other Neonates with Conditions Originating in the Perinatal Period. For psychiatric stays, the grouper's MDC 19, Mental Diseases and Disorders, is also enhanced.

Annually, beginning with July 1, 1992, updated versions of the Medicare grouper will be used by the WMP. The Medicare grouper version, which is released by CMS for use by Medicare beginning on October 1 of each calendar year, will be implemented for MA discharges occurring on and after July 1 of the subsequent calendar year. (For example, on October 1, 1991 CMS began to use Version IX of the Medicare grouper. Therefore, for dates of discharge on and after July 1, 1992, the WMP will apply that Version IX grouper.)

5140 DRG Weights

DRG weights reflect the relative resource consumption of each inpatient stay. The weights are determined from an analysis of past services provided by hospitals, the claim charges for those services and the relative cost of those services. WMP recipient inpatient hospital claims are used in order that the weights which are developed are relevant to the types and scope of services provided to WMP recipients.

Annually, beginning with July 1, 1992, revised DRG weights will be established based on (1) the updated version of the Medicare grouper, (2) more current claims information and (3) more current inpatient hospital cost report information.

5140.1 Claims Used. Claims for a period of at least three years for WMP certified hospital providers in Wisconsin are used. The selected period of claims is not to end more than twenty-four months nor less than nine months prior to the July 1st day on which the revised DRG weights are to be implemented. Claims not covered by WMP's DRG based payment system are not used. These are claims for which payment is made at rates determined under Sections 6000 and 7000. Also not used are claims from any hospital designated a critical access hospital (CAH) during the selected period of claims. This exclusion of claims applies to hospitals newly designated as a CAH or discontinued as a CAH anytime during the selected period of claims.

5140.2 Cost Report Used. The WMP uses the cost report for each hospital's most recently completed reporting period for which an audit adjusted cost report is available to the Department as of the February 28th date prior to the July 1st day on which the revised DRG weights are to be implemented except the Department may, at its option, use audited cost reports it receives later. Costs are inflated as described below for the calculation of weights.

5140.3 Weights Calculated.

The updated version of the Medicare grouper described in section 5130 above is applied to the historical claims from the period described in subsection 5140.1 above. Each claim is classified to and assigned its appropriate diagnosis related grouping (DRG) by the grouper.

The cost of each inpatient hospital claim is calculated. This is a hospital-specific claim cost that requires correlating the services charged on the claim to related cost centers of the hospital's cost report. For each claim, accommodation charges for the hospital stay are multiplied by the cost-to-charge ratio of accommodation cost centers in the respective hospital's cost report. The result is the cost of accommodations for the hospital stay. Ancillary service charges are multiplied by the cost-to-charge ratio of ancillary cost centers in the respective hospital's cost report providing a cost for ancillary services. Acquisition charges for transplanted organs are multiplied by cost-to-charge ratios for the respective organ. The resulting accommodation cost, ancillary service cost and organ acquisition costs of each claim is summed resulting in the total cost of the inpatient stay.

The cost of each inpatient stay is further standardized (or adjusted) for area wage differentials and reduced for the cost attributed to capital costs, direct medical education costs and outlier costs.

Each claim's cost is inflated by an inflation multiplier to the current rate year. The inflation multiplier is derived from indices in the publication, "Health-Care Cost Review", that is published quarterly by Global Insight, Inc.. Specifically used are the total market basket indices from the tables entitled "CMS Hospital Prospective Reimbursement Market Basket."

The average cost of the claims by each DRG is calculated. Also, a combined overall average cost of all DRG claims is calculated. However, excluded from this overall average are claims grouped to MDC 15, Mental Disease and Disorders, for Milwaukee County Mental Health Center. The weight for each respective DRG is the average cost of the respective DRG's claims divided by the combined overall average cost. In this way, weights are established for over 550 DRGs.

Random anomalies and incongruities in the resulting weights are reviewed and analyzed in the light of the prior year weights and the cost and volume of claims involved. The questioned DRG weights are adjusted, if considered appropriate, to a reasonable amount based on the analysis. It should be noted that low-volume DRGs are especially vulnerable for significant year-to-year swings in their weight. A significant decrease in the weight of any individual DRG is limited unless cost, volume and central tendency and deviation data justify the significant decrease. A listing of the resulting proposed and final DRG weights are disseminated to in-state and major border status hospitals.

5140.4 Cochlear Implants.

A separate weighting factor is provided for inpatient hospital stays for cochlear implants. Payment is available upon written request by the hospital for payment at this weight and is only available for a claim that covers cochlear implant surgery and the cost of the apparatus. This is a low volume inpatient procedure for Medicaid recipients but is significantly more expensive than the broadly inclusive DRG #49, major head and neck procedures, in which cochlear implants are grouped (assigned). A claim for surgery without the apparatus cost will be covered under DRG #49. The cochlear implant weight was established based on the cost of 17 inpatient stays from February 1991 to August 1993. This set of claims covered some WMP recipients but mostly persons not covered by WMP. When a sufficient number of inpatient claims from a current period of no more than 7 years is available for WMP recipients receiving cochlear implants, a weight will be calculated based on those claims. The method of calculating a weight is that described above for other weights.

5150 DRG Weights For MDC 15, Mental Diseases and Disorders

The WMP has expanded the nine standard diagnosis related groupings (DRGs) of MDC 15 for Mental Diseases and Disorders. For each of the DRGs, separate weighting factors are constructed for two age ranges: ⁽¹⁾ over age 17 and ⁽²⁾ age 17 and younger. The result is 18 weighting factors. These weighting factors apply to hospital stays for mental diseases and disorders in acute care hospitals and in hospital institutions for mental disease (IMD) except Milwaukee County Mental Health Center.

A separate schedule of 18 DRG weighting factors are constructed for the Milwaukee County Mental Health Center (MCMHC) for hospital stays classified to MDC 15, Mental Diseases and Disorders. Weights are calculated as described in section 5140.3 above using average cost by DRG for hospital stays in the MCMHC that are classified to MDC 15.

As noted in subsection 5140.3, random anomalies and incongruities in the resulting weights are reviewed and adjustments made if considered appropriate.

Page 7

(TN # 00-007)

TN # 03-009
Supersedes
TN # 00-007

APR 22 2004
Approval Date _____

Effective Date: 07/01/03